

State Notes

TOPICS OF LEGISLATIVE INTEREST

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The Dispute between the Detroit Medical Center and Wayne State University **By Steve Angelotti, Fiscal Analyst**

The Detroit Medical Center (DMC) and Wayne State University's medical school have had several disputes regarding medical services and reimbursement over the past few years. The latest flare-up began earlier this year when the Detroit Medical Center, acting on the advice of its legal counsel, began to withhold Medicaid revenue from Wayne State.

The two entities have had a long-standing relationship that has been close in both geographic and financial terms. Wayne State University staff, particularly the private University Physicians Group (UPG), provide clinical services on behalf of the DMC and the DMC provides residency opportunities for Wayne State University medical students.

The relationship has been complicated by the location of both the DMC and Wayne State in Detroit, a city with large numbers of people either on Medicaid or without health insurance altogether. Thus, each faces issues with undercompensated and uncompensated care, which has led to financial pressures. This has been a factor in their disputes in recent years, disputes that have often played out in the media and have received attention from the Legislature.

The most recent issue, regarding reimbursement for Medicaid services, came to public and legislative attention earlier this year. The Senate Health Policy Committee held a hearing on the dispute on June 4, 2008, taking testimony from representatives of both entities. The House of Representatives considered possible boilerplate language in the Higher Education budget that would have forced Wayne State to end its relationship with the University Physicians Group or face loss of its appropriations. In the end, the House adopted a much less stringent piece of boilerplate language regarding potential conflicts of interest.

Among the key issues in dispute over the years are finances and clinical service contracts, although the present issue is much more focused on the former, the financial end of things.

During a dispute over payment two years ago, Governor Granholm appointed a mediator who negotiated an agreement that was signed by all parties on November 22, 2006. This agreement, which took effect on January 1, 2007, specified which joint clinical services and residency contracts would be continued.

The agreement also effectively freed up both entities to seek other partners for certain services. For instance, Wayne State was allowed to provide clinical services such as dermatology, ear, nose, and throat (ENT) services, and urology through agreements with other non-DMC hospitals.

The November 2006 agreement also specified amounts to be paid by the DMC for services provided by Wayne State physicians. These included \$19.2 million to be paid annually for "indigent care". Roughly \$10.0 million was intended to help cover the costs of treating Medicaid managed care clients and roughly \$9.0 million was intended to help cover the costs of treating the uninsured. The apparent intent on the Medicaid side was to raise total reimbursement for Medicaid managed care outpatient services to roughly that paid by major insurers such as Medicare and Blue Cross.



Beginning in late 2007, the State created a new program entitled, "Specialty Network Access Fees" or SNAF. Payments were and are being made through Medicaid health maintenance organizations (HMOs) to publicly affiliated providers (associated with Wayne State, Michigan State University, the University of Michigan, and Hurley Hospital in Flint). Thus, on top of the ongoing \$10.0 million from the DMC for Medicaid managed care clients, Wayne State clinics are now receiving an additional \$17.0 million from this new State program.

The DMC has raised concerns that these new payments may leave it vulnerable to the provisions of two Federal laws, the Stark Act and the Anti-Kickback Statute. The DMC argues that there is a risk of a violation of these laws if there exists a referral relationship between an entity and a provider. The classic example of a questionable referral relationship is a physician who refers a patient for magnetic resonance imaging (MRI) services at a facility that is owned in whole or in part by that physician.

There are "safe harbor" provisions that allow referrals in certain situations, as long as the compensation does not exceed "fair market value". It appears that the DMC concedes that its referral relationship with Wayne State physicians fits under the "safe harbor" provisions, but that still leaves the issue of whether the compensation exceeds "fair market value". Wayne State, on the other hand, argues that the reimbursement does not exceed "fair market value" and that the payments are not payments in exchange for referrals and thus do not violate Federal law.

The present dispute began after the DMC sought an opinion from the law firm Foley & Lardner LLP on the new SNAF payments and the possible issues related to the Federal laws. Foley contended that it was "logical to infer" that the total payments being made, including the SNAF payments, exceeded fair market value and further claimed that this could put the DMC at risk of violating Federal law. The firm advised the DMC to withhold some of its payments in order to reduce reimbursement to "fair market value". The projected reduction was in the range of \$10.0 million per year, in other words the entire DMC payment assumed to be allocated for Medicaid services. The DMC then took action to reduce the payments to Wayne State.

Reducing the agreed-upon payment puts the DMC in clear violation of the November 2006 agreement. On the other hand, the DMC argues that it had to reduce the payment to keep total payments within "fair market value" and avoid legal liability under the Stark Act and the Anti-Kickback Statute.

Wayne State then sought an opinion from the law firm Hall Render on the issues at hand. According to Hall Render, the payments were not in excess of "fair market value". The firm also questioned whether payments made under the November 2006 agreement can be construed as payments made in exchange for referrals.

Due to the reduced payments, Wayne State has moved ahead with layoffs and there are now disputes over whether this has led to reduced access to health care for the indigent and the uninsured.

Each side has made arguments over the definition of the term "fair market value" and this definition could well be the crux of the issue. If one accepts the DMC's contention that Federal



law requires reimbursement for DMC clients referred to Wayne State physicians to be at "fair market value", then "fair market value" is the central issue.

Hospitals report to the State each year data on their finances, including Medicaid payments and costs. (The Senate Fiscal Agency has the hospital cost reports from 2006 and will receive the reports for 2007 later this summer.) When one examines fee-for-service hospital reimbursement for outpatient services, one sees that Michigan hospitals, in 2006, received about \$115.0 million in Medicaid reimbursement and faced costs of \$250.0 million. That is about 46 cents of reimbursement per dollar of cost (excluding \$17.0 million in outpatient graduate medical education payments). It is also known that Medicaid rates for physician and outpatient services are at or less than 60.0% of Medicare rates. This implies that Medicare payment rates are still less than costs on the outpatient side, at perhaps 75.0% to 80.0% of cost. Thus, any effort to raise total outpatient reimbursement to Medicare levels still would leave reimbursement short of cost by 20.0% to 25.0%.

With this information in hand, the question becomes, "What is fair market value?"

Is "fair market value" the rate paid by the largest insurers, such as Medicare or Blue Cross, whether or not that is less than cost, as is apparently the case with Medicare reimbursement for outpatient services?

Is "fair market value" an amount sufficient to cover costs, or 100 cents on the dollar? Is it an amount slightly in excess of 100 cents on the dollar, in order to assure a small profit on services?

Given that Medicaid is a relatively marginal payer in the general outpatient services market, is "fair market value" an amount sufficient to cover marginal costs rather than average costs? In other words, the total cost of seeing 100 patients in one week may be \$10,000, meaning an average cost of \$100 per patient seen. However, the marginal cost of seeing one additional patient, the 101st patient, almost certainly would be lower. For a marginal payer, the marginal cost may be the best measure of costs incurred.

On the other hand, since Medicaid is much more than a marginal payer in the City of Detroit, is average cost a better measure than marginal cost?

These questions cannot be expertly addressed in an article of this nature. There is little chance of resolution until neutral outside parties, with expertise on "fair market value" and Federal law, move this process along.

At present, there is some hope that the process will move toward a resolution. Wayne State has reported the concerns about a potential violation of Federal statute to the Federal Office of Inspector General (OIG). Both Wayne State and the DMC have provided data to the OIG and it is hoped that the OIG will rule one way or another and resolve the situation. If the OIG rules that the total payments to Wayne State are in compliance with "fair market value" or that "fair market value" is not an issue in the first place, the payments should resume.

Wayne State has asked the DMC to escrow the disputed funding, but the DMC has refused to do so. The DMC has argued that if false information has been reported to the OIG, then the

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DMC could be liable. It claims that even if Wayne State provided incorrect information to the OIG, the DMC could be liable. The DMC has demanded that Wayne State give the DMC copies of all information that Wayne State provided to the OIG; Wayne State contends that some of that information is proprietary. In response, the DMC is refusing to escrow the funding. It is not clear, however, why a dispute over the sharing of information has any relationship to the issue of putting the disputed funding into escrow.

If the OIG were to rule that the total payments are not in compliance with "fair market value", then there would be further issues to resolve. The first issue would be how far in excess of fair market value are the payments. The next issue would be the process by which Wayne State would make restitution – and to whom. The final issue would be which payments would be ruled to be excessive and would have to be reduced in the future – the payments made by the DMC under contract to Wayne State, or the payments made by the State of Michigan under the SNAF program.

Even if this particular dispute is resolved to the satisfaction of the two parties, it appears that there will continue to be further disputes. As already noted, each entity faces financial stresses and each will have to continue to deal with the other.

While there will continue to be an expansion of relationships between the DMC and other medical schools and geographic areas outside of Detroit, its primary focus will remain the City of Detroit. Its largest partner will almost certainly still be the Wayne State University Medical School. Similarly, Wayne State will likely expand its relationships with other hospital systems, but its primary focus will remain the City of Detroit and its largest partner almost certainly will still be the Detroit Medical Center. As each entity reaches out to develop outside relationships, it can safely be predicted that new disputes about payments and such relationships will arise.

For better or worse, the two entities' fates are intertwined. It does appear, however, that the rockiness of the relationship will continue into the foreseeable future. Such difficulties will negatively affect not only the Detroit Medical Center and Wayne State University but, more significantly, Medicaid clients and uninsured individuals in the City of Detroit and surrounding communities.